



MRI Patient Screening Form

Patient Information

Date: _____ Exam: _____
 Patient Name: _____ Physician: _____
 DOB: _____ Patient Weight: _____
ANY previous surgeries: _____

Patient History

Pacemaker or retained wires/leads	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Claustrophobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Electronic implant/device	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cochlear implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Small bowel endoscopy capsule	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing aids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurostimulator/Defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Body piercings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnant/Breast feeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medicine patches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aneurysm clips	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Retina repair	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Brain or spinal shunt	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Brain surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Carotid clips	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast tissue expanders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart stents	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any joint replacement	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dentures/Partials	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infusion pump/Insulin pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Penile implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grinding/welding of metal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	IUD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bullets/shrapnel	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ear surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any eye injury with metal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tattoos	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prior Surgery to scan site	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Permanent makeup	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recent surgery (last 6 wks)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Surgical clips	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal aneurysm surgery/graft	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle cell anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metal plates, pins, rods, screws	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal hx of Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetic	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any latex allergy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prior MRI? Where? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Barium study in 30 days	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any allergies to medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please list: _____		

Important Instructions:

**Before entering the MRI environment, you must remove all metallic objects including hearing aids, keys, pager, cell phone, watch, safety pins, money clip, credit cards, magnetic strip cards, pens, pocket knife, hemostats, nail clippers, tools, guns, handcuffs, etc.

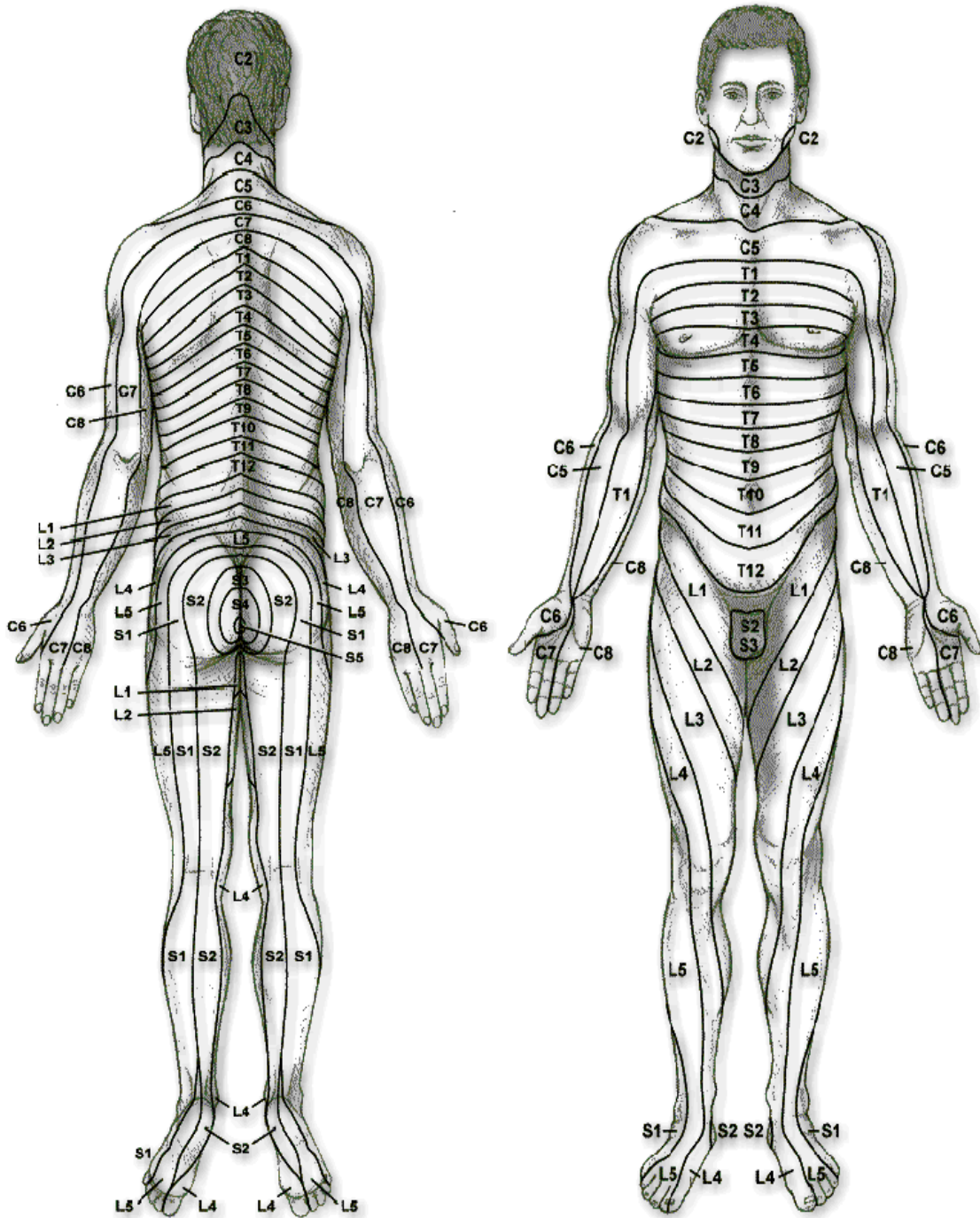
Please consult the MRI technologist or Radiologist if you have any questions or concerns **BEFORE entering the scan room.

The above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____

If you are having a brain and/or spine exam, please see reverse side



On the above diagram, please shade in the areas where you have pain and/or numbness